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Mass hysteria among schoolchildren

SIR,—We appreciate Minerva's comments (2 April, p 1151) on the press coverage of the outbreak of mass hysteria among schoolchildren (mainly girls) in Boston, Massachusetts. Her remarks were particularly apt as they coincided with a similar episode that occurred in the West Bank during the end of March and the first week of April. Three hundred and twenty three schoolgirls in the Jenin district complained of symptoms resembling those in the Boston epidemic—abdominal pain, nausea, and dizziness. They were joined by other schoolgirls in the ensuing days.

The outbreak received the attention of the media and was reported variously: the girls had been "poisoned by an unidentified chemical substance," were suffering from a "mysterious malady" caused by some "environmental irritant," or were suffering from "the inhalation of some kind of gas." A yellow powder found on a few windowsills was suspected of containing hydrogen sulphide but was subsequently identified as pollen.

Two teams of foreign experts carried out extensive investigations. The report prepared by an Australian epidemiologist and an Italian toxicologist was presented at the World Health Organisation 36th annual conference in Geneva on 11 May. It concurred with those of the team from Atlanta and the Israeli Health Ministry and concluded that there was no evidence of environmental toxins and that the epidemic was induced by "anxiety." Unfortunately, the findings were not awarded the same publicity as the events preceding them.

We hope that Minerva's recommendations that "all journalists be taught the features of hysteria and a few other medical basics" have been noted and will be adopted.

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Smoking, lung function, and body weight

SIR,—Dr T Khosla and Dr C R Lowe (14 May, p 1578) point out that one should not infer from our data (22 January, p 249) that lung function is unaffected if there is no overt airflow obstruction. We were aware of this, as can be seen from reference four of our paper, which presents the detailed lung function results of the studied subjects.¹

We showed that about half of the smokers without spirometrically detectable airflow obstruction (forced expiratory volume in one second (FEV₁)/vital capacity >66%) had small airways disease, defined as an increased slope of the nitrogen alveolar plateau or an increased closing capacity, or both. These smokers (n=32) had significantly lower values of FEV₁ (2.98±0.44 litres, 0.63±0.08 litres/m²) than smokers without small airways disease (n=36). The latter had values of FEV₁ (3.34±0.43 litres, 0.71±0.07 litres/m²), as well as of all other indices, that were indistinguishable from those of the asymptomatic non-smokers (3.52±0.51 litres, 0.72±0.08 litres/m²). We had not considered it necessary to discuss these aspects, which were beyond the scope of our paper and had already been presented elsewhere.

Dr Khosla and Dr Lowe also say that the ratio of FEV₁ over the forced vital capacity is a misleading indicator of impaired lung function since forced vital capacity is also decreased in smokers who "may not make an all out effort to expel the air in [their] lungs during measurements of forced vital capacity for fear of coughing." Both forced vital capacity and FEV₁ are derived from an expiratory manoeuvre during which more than half the volume is expelled at high flow rates. It is not surprising, therefore, that in patients with airway obstruction forced vital capacity is less than the slow vital capacity, which is recorded at low flow rates. This explains the loss of sensitivity of FEV₁/forced vital capacity compared with FEV₁. In our study we related FEV₁ to the slow vital capacity. Values of vital capacity were similar in our groups with and without airflow obstruction (4.29±0.64 litres and 4.32±0.59 litres respectively).

Finally, in contrast to what Dr A Keys writes (4 June, p 1883), our observation, fully confirmed by Dr F Kauffmann (16 April, p 1280), shows more than just "the inverse relation between smoking and relative weight," "simply [reflecting] compulsion for oral satisfaction." Our data support the idea that only those whose lungs are being adversely affected by smoking tend to lose weight.

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¹ Nemery B, Moavero NE, Brasseur L, Stănescu DC. Significance of small airways disease in middle-aged smokers. *Am Rev Respir Dis* 1981;124:232-8.

Doctors should learn 100 words of Punjabi or Hindustani

SIR,—Some three years ago, having many Asian patients and not liking a 10 year old boy translating his mother's comments on gynaecological problems, I decided to learn some of their languages (4 June, p 1827). I was encouraged by a Hindu colleague and approached the community relations department at Newcastle Civic Centre. It was most helpful, and one of the officers lent me a dozen books of his own to read covering the religions, cultures, and customs of the various ethnic groups of the Indian subcontinent. He also provided me with a teach yourself Hindi book and a teacher, who came to my surgery and gave me lessons. In less than six months I was able to manage a surgery.

My colleague also arranged for me to be introduced to the president of the Sikh temple, and these people encouraged me and helped me to improve my pronunciation. I practised in odd bits of free time. I was working full time as a principal in general practice at the time and must admit to giving

up a lot of my free time for a few months. I must emphasise that I learnt only nouns and verbs and phrases for medical use—I would have been no use discussing the weather. The spin off is that the patients very much appreciate your efforts to meet them and understand their customs and will only too readily explain what is the right thing to do in the case of, for example, death. My patients were grateful and pleased that I had tried to reach them, and the good will generated was enormous. I am sure it was very good for the practice.

Asian community nurses also can give you help with colloquial phrases and feedback on problems in the practice. If one shows willing there is plenty of help to be had for free. I found a degree of friendship and kindness among Asians of all faiths that I had not known before; and the object of the exercise, the care of non-English speaking Asian women, became very much easier. They gave me trust which was not there before, presumably because I had become known on the Asian grapevine and because they knew that I was trying to treat them bearing their religious and cultural backgrounds in mind.

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Hypnotics and anxiolytics

SIR,—Dr N Hockings and Dr Brian R Ballinger (18 June, p 1949) rightly say that the important difference among benzodiazepines is duration of action, but I think that their categorisation into short acting and all others does not quite reflect the present position and that it would be better to distinguish the very short acting drugs. Into this last category comes triazolam (Halcion), for which the authors quoted an elimination half life of five hours, but most publications give two to four hours—for example, Jochemsen *et al* now report a mean of 2.4 h.¹ Triazolam therefore would be better not loosely classed with lormetazepam (Noctamid), which has a half life of 10 hours, four times as long.

Last year, Dr K Morgan and I reported that triazolam 0.5 mg nightly for three weeks led to increasing daytime anxiety among middle aged poor sleepers.² Hostile letters were provoked in your columns. From the USA, however, Kales *et al* now confirm that during a second week of triazolam 0.5 mg nightly, "tension or anxiety increased above baseline."³ Like ourselves, they interpret the findings as daytime withdrawal phenomena. Moreover, Kales *et al* report early morning insomnia as a positive consequence of triazolam and its very rapid elimination—that is, wakefulness as a late night withdrawal phenomenon. Most doctors are familiar with morning insomnia, anxiety, and tension feelings provoked by the ingestion of large doses of another very rapidly metabolised hypnotic and anxiety relieving agent, alcohol.

In your journal in 1973 my colleagues and I wrote of the same phenomenon as a consequence of accustomed amylobarbitone sodium: a "latenight withdrawal rebound as the bedtime dose of drug is metabolised," providing a reason why patients may find "confirmation of their supposed need for a hypnotic at a time when the hypnotic itself is perpetuating the poor sleep."⁴

The very long acting, cumulative hypnotics like flurazepam (Dalmane), referred to by